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Nursing students' experiences with faculty incivility in clinical education context: A qualitative systematic review and meta-synthesis

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Abstract

Objective: The aim of this study is to synthesize the quantitative evidence on the experiences and perceptions of incivility in clinical education of nursing students.

Design: A systematic review was conducted to synthesis qualitative studies. Relevant papers published from 1990 until week 2 of January 2018 were searched using electronic databases including CINAHL, PubMed (MEDLINE), ProQuest Central, ProQuest Education Journals, ProQuest XML-Dissertations and Theses, Web of Science, Embase, etc. Two reviewers appraised the methodological quality and extracted relevant data of each included study independently. Meta-aggregation method was used to synthesize data.

Setting: All healthcare setting.

Participants: Current nursing students on clinical education or those who have already completed their clinical education.

Outcomes: The experiences and perceptions of incivility in clinical education of nursing students.

Results: A total of 3397 studies were returned from search strategies. Eighteen studies fulfilled the inclusion criteria and were included in the meta-synthesis. Six synthesized findings were identified, covering features of incivility, manifestations of incivility, contributing factors, impacts on students, coping strategies, and suggestions.

Conclusions:

The results showed the experience of incivility in clinical education was common and had negative impacts on nursing students and nurse profession. We suggest nursing students try to cope with incivility positively. Nurse managers and clinical preceptors should have the awareness of the prevalence and impact of incivility, and implement policies and strategies to reduce incivility for nursing students. Hospitals and universities need to have an immediate response person or system to help nursing students confronting incivility, and create an open communication environment.

Keywords: Nurse education; Incivility; Systematic review; Meta-synthesis

Strengths and limitations of this study

- We used JBI meta-aggregation method to synthesize qualitative data, which avoided re-interpreting of original studies.
- We performed a comprehensive search strategy to find all relevant studies in nine academic databases and four grey literature databases.
- Both journal articles and thesis were included in order to provide an unbiased result.
- We only included studies in English. All the included studies were conducted in the United States, European countries and Australia. Cultural variation may have variation in individual responses to incivility.

Introduction

Incivility is defined as a rude and deviant act characterized by a low-intensity discourteous behavior with or without intent to harm, offend and humiliate the target.[1, 2] For decades, nurse-to-student incivility is prevalent in clinical settings. The unfortunate idiom "nurses eat their young" has been used for over 30 years.[3] Previous studies have shown that nursing students had the experience of being bullied, harassed and unfairly blamed by clinical faculty. Results from a study conducted by Clark and Springer revealed that over 70% of 356 respondents believed incivility in the nursing education is a moderate or serious problem and increased in the last five years.[4] A survey conducted in Oman showed over 40% percent of the respondents experienced different forms of incivility, including being disrespectful, being unprepared for class, cancelling schedule activities without warning, etc..[5] The literature suggests there are key factors that contribute to incivility.

Rowland and Srisukho found gender, class standing, average grade, informal interaction between faculty and students, and academic achievement were the key factors associated with incivility toward students.[6] Results from Vink et al. indicated that factors contributing to incivility could be categorized into three themes, including academic factors, psycho-pathological factors, and social factors.[7] Other factors identified by previous studies also included policies on uncivil behaviors, political atmosphere, and environmental factors.[8, 9]

In the face of high rates of nurse turnover and workforce attrition in nursing, nurse educators and managers realized that incivility in clinical settings can be contributory, as it can be harmful to both individuals and their organizations. Anthony et al. and Kinley found incivility can negatively influence students' confidence, question whether they are completely incompetent being a nurse, and also lead to a high level of turnover among new graduate nurse during their first two years' employment.[10, 11] Results from studies conducted by Seibel and Milesky et al. showed victims of incivility suffering from physical and emotional distress that affect patient care and was related to patient safety.[12, 13] Report from the Joint Commission showed uncivil behavior in the health care setting could lead to medical errors, poor clinical outcomes, low patient satisfaction, and increased costs of care.[14]

Nursing faculty incivility in clinical education has also been reported in the literature. Altmiller and Anthony & Yastik conducted focus group interviews to describe the phenomenon of incivility in undergraduate nursing program.[15, 16] Although the qualitative research yielded in-depth information from a small sample of participants, however, the external validity and transferability of single study was still limited. A variety of aspects of the experience of faculty incivility need to be integrated to produce more robust evidence across multiple quantitative studies. It is still crucial to understand the phenomenon deeply to use mindfulness solutions to inform the practice and transform the culture of the workplace. In order to make a comprehensive picture of this phenomenon we used the approach of meta-synthesis to manage and report findings from multiple qualitative research studies.[17]

The aim of this study is to synthesize the evidence on the experiences and perceptions of incivility in clinical education of nursing students. Specifically, the review addressed the following research question: 1) What behavior in the clinical environment did student consider incivility? 2) To what extent did these behaviors affect them? 3) What strategies did they use to cope with incivility?

Methods

We used meta-aggregation approach to conduct a systematic review of qualitative studies, and followed the Enhancing Transparency in Reporting the Synthesis of Qualitative research (ENTREQ) statement (Appendix I).[18]

Inclusion Criteria

Inclusion criteria included: 1) participants were current nursing students on clinical education or those who have already completed their clinical education; 2) phenomena of interest focused on the perceptions and experiences of incivility from faculty during clinical education; 3) context: faculty incivility must have occurred in clinical settings or during clinical education; 4) qualitative studies including, but were not limited to, ethnography, phenomenology, narrative study, grounded theory, and case study. Mixed-method studies with a narrative description of faculty or student voices describing the phenomenon under study were also considered, and; 5) published in English.

Search Strategy

We included both published and unpublished papers. A three-step search approach was conducted in this study. Firstly, we searched the MEDLINE (via PubMed) to analyze the text words and the index terms which could be used in the comprehensive search. Second, a comprehensive search was conducted across all included databases with a usage of keywords and index terms. Databases included: CINAHL, PubMed (MEDLINE), ProQuest Central, ProQuest Education Journals, ProQuest XML-Dissertations and Theses, Web of Science, Embase, EBSCO Discovery Service and PsycINFO. The search for unpublished studies included the Open Grey, Conferences proceedings, and Deep Blue Library. Relevant papers published from 1990 until week 2 of January 2018. Search terms included incivilit* OR bully* OR workplace violence OR uncivil OR aggression* OR harass*. The search strategy for PubMed (MEDLINE) is available in Appendix II. In the third step, additional studies were searched by hand to screen the references of related studies. Search results were imported into Endnote X8, which was used to manage the literature.

Critical Appraisal

Two reviewers appraised the methodological quality of each included study independently (ZZ & XWJ) using the Joanna Briggs Institute (JBI) critical appraisal tool for qualitative studies.[19] Disagreements were resolved through discussion.

Data extraction

The JBI standardized form was used to extract qualitative data. The data extraction form included following domains: study (Year), country, design (method of data collection), interest of phenomenon recruitment and participants, and main findings including relevant illustrative quotations. Relevant data were extracted by two reviewers (ZZ & XWJ) independently. Disagreements were resolved through discussion.

Data synthesis

The JBI meta-aggregation method was used to synthesize data. Meta-aggregation is one of the approaches for synthesizing qualitative evidence which is based on the primary author's findings and may generate recommendations for action.[19] Data extraction, comparison and synthesis were conducted by using JBI-SUMARI.[20] The procedures involved four steps: 1) thorough repeated reading of paper,

verbatim statements and accompanying quotations were extracted from each study by the primary reviewer (XWJ). Only those findings being identified as highly correlated with our phenomenon of interest were extracted from each study. To ensure rigor, the second reviewer (ZZ) check all the extractions. 2) Two reviewers (ZZ & XWJ) independently assigned the level of credibility for each research finding. All disagreements were resolved through discussion. If there was more than one quotation for the same finding, we assigned the highest level of credibility. 3) Findings rated as unequivocal or credible were aggregated them into categories on the basis of similar meaning. Findings rated as unsupported were eliminated from further analysis. The categories were determined by primary reviewers (XWJ) and affirmed by the second reviewer (ZZ). Disagreements were resolved by consensus. 4) Categories with commonality were further integrated into synthesized findings by primary reviewers. The synthesized findings and recommendations were examined by all co-authors who involved in nursing education

Confidence in the findings

The synthesized findings were assessed by using JBI ConQual approach to determine the level of confidence.[21] The level of confidence was rated as high, moderate, low, or very low based on the dependability and credibility from the included study.

The dependability for the each included study was determined through the evaluation of five criteria on the JBI critical appraisal for qualitative studies. The criteria evaluate the congruity between the study methods and study objective, and methods of data collection and analysis. The criteria also evaluate whether the study located the study culturally or theoretically and have a statement about the impact of the researcher on the study. The dependability for the synthesized finding was determined by the dependability for each included study.

The credibility for each research finding was determined by the congruity between study's interpretation and participants' quotations. The credibility for each finding was rated as unequivocal (U), credible (C), or unsupported (UN). The credibility for the synthesized finding was based on the level of credibility of each research finding. If all research findings were unequivocal, the credibility of the synthesized findings was regarded as high. If synthesized findings include both unequivocal and

credible research findings, the credibility of the synthesized findings was regarded as moderate. If synthesized findings include only credible research findings, the credibility was rated as low. The ConQual score was downgraded from high to very low on the basis of dependability and credibility.

Results

Literature search

The outcomes of literature search were outlined in Fig.1. Initially, a total of 3397 studies were returned from search strategies. After screening the titles and abstracts, we reduced the number papers to 53 for full text evaluation. Subsequently, 18 studies fulfilled the inclusion criteria and were included in the meta-synthesis.[15, 16, 22-37]

Study Description

The study characteristics are summarized in Table 2. Among 18 studies, 15 studies were published papers[15, 16, 22, 24-31, 33, 34, 36, 37] and three were PhD thesis.[23, 32, 35] Six studies used individual semi-structured or unstructured interview to collect data, [23-25, 27, 32, 35] four studies used focus group interview,[15, 16, 31, 34] four studies used open-ended questionnaire,[22, 26, 28, 30] two studies used both individual and group interviews,[29, 33] and two studies collected data from the diary and stories written by nursing students.[36, 37] Most of the included studies were published from 2012 to 2017 (n = 11).[15, 22, 23, 25, 27, 28, 32-36] Studies were conducted in five different countries: The United States (n = 8),[15, 16, 23, 24, 27, 34, 45, 37] the United Kingdom (n = 4),[29, 32, 33, 36] Australia (n = 4),[22, 25, 26, 30] Finland (n=1),[28] and Turkey (n=1).[31] Six studies reported the recruitment was across multiple universities/hospitals.[15, 24, 28, 29, 33, 34] Two studies recruited participants through online platforms.[22, 30] The total number of the nursing students included in this systematic review was 1182. Among all participants, 348 participants joined the interview, and 834 participants completed the questionnaire or diary. The sample sized ranged from 4[23] to 430 participants.[22]

Quality Assessment

Table 1 summarizes the quality assessment of the 18 selected studies. Among 18 studies, all the studies have a similar interest of phenomenon, methodology, and methods of data analysis. Only one study reported the potential beliefs and values of the authors which might have influenced the findings.[23]

Three studies reported the authors' role in the study which may have potentially influenced the interpretation of findings.[23, 32, 35] One study did not provide representations of participants and their voices.[15] Two studies did not report on the ethical approval process.[15, 29]

Review finding

Eighty findings were retrieved from 18 articles. Six synthesized findings were identified. Of these, 70 findings were rated as unequivocal and 10 as credible. An overview of these synthesized findings is summarized in Table 3.

Synthesized finding 1

There are different types of incivility that can be experienced by nursing students. Some are noticeable while others can be more subtle which are hard to be proved. Most of the nursing students are unprepared for the incivility from multiple perpetrators.

This synthesized finding was originated from six findings and grouped into one category. Many of the studies describe the features of the incivility. The nursing students perceived the incivilities in the clinical workplace were diverse. The forms of incivility could be either overt or covert, and verbal or non-verbal.[22, 25] Many nursing students believed incivility in the clinical workplace was pervasive and recurring, and experiencing incivility during clinical education was unavoidable.[22, 25, 34] A nursing student indicated the incivility as a "rite of passage".[22]

"it is a serious issue, more of the bullying occurs from registered nurses, a profession where we are meant to care for one another. They are eating their young and wonder why people want to quit nursing. They forget they were just like us once".[22]

Due the idea of equality between nursing students and clinical staff did not seem viable, the incivility was apparently ongoing and was not just a onetime occurrence.[26, 35] In this hierarchical system, nursing student believed that in order to succeed, they had to accept their role was defined by those with power and authority.[15, 26, 35] They described perceiving incivility from multiple perpetrators, including clinical

instructors, other nurse staff, physicians, healthcare assistants, and ward cleaner.[22, 28-31, 35] However, students felt difficult to prove being bullied or maltreated.[28]

Synthesized finding 2

Faculty incivility in the clinical education context toward nursing students manifests as lack of professionalism in the workplace, being unrespect and unfair toward nursing students, and letting nursing students feel unwanted and ignored in the workplace. What's worse, some manifestations including physical abuse and sexual harassment violate the law

This synthesized finding was originated from 28 findings and grouped into five categories. The acts of incivility in clinic education can be categorized into lack of professionalism, being unrespect, being unwanted and ignored, inequality, physical abuse, and sexual harassment.

Nursing students noted a range of manifestation as lack of professionalism from medical staff including: failing to provide learning opportunities or guidance,[31, 32] having rigid expectations for students' abilities,[22, 24, 27, 33, 37] excessive using of students for legwork or own gains,[31-33, 37] arbitrary changes in syllabi, assignment and schedule,[24] student being questioned inadequately,[35] giving constant criticism and negative feedback,[27,32,35] and not protecting students for safety.[32]

> *"A nurse said, 'You are wasting your time with care plans. We used to do them, but they do not work.' After hearing this, I lost confidence in my education".*[31]

Fourteen studies noted unrespect behaviors from medical staff. Characteristics exemplifying unrespect behavior included belittlement,[15, 24, 27, 29, 30, 35, 37] being condescending,[24, 34] intimidation,[27, 33, 34] criticism on personality,[22, 37] humiliation in front of staff and patients,[22, 23, 26-28, 33, 37] talk about students behind back,[22] calling students by derogatory names,[22, 32-34] shouting at students,[28, 33] and having hostile body language (e.g. eye rolling and without eye contacts).[22, 36, 37]

"… and then in the end… she just got a bit angry with me sort of in front of the patient. . . and said some things like (coughs) I didn't quite think were acceptable to say in front of the patients… rather than helping me she just got angry with me".[33]

Twelve studies noted unwanted or ignored behaviors bestowed by medical staff towards nursing student. The forms included making nursing student feeling like a nuisance,[16, 25, 30, 33-37] not letting students involve into nursing activities,[22, 32] refusal to answer, help or support,[15, 22, 30, 32, 33, 35, 37] and not permitting student to use staff room.[22, 26]

"How wrong I was. I have never felt so unwanted in my life. The nursing staffs made me feel like a complete nuisance…I don't think she even made eye contact with me… She seemed annoyed by my presence… ".[37]

Inequality for all students was identified as another form of incivility. Bias commonly based on gender, race, appearance, and behaviors.[15, 22, 24, 27] Some faculty favored male nursing students and the younger nursing students, and were more positive in their communications with them.[15, 24] The students with bizarre behaviors would have more challenge.[25, 30, 31] Some nursing student admitted they were fear to be targeting and avoided any interaction at all with certain instructors.[15, 27]

"On my clinical placement, I was immediately judged by one staff member who continuously embarrassed me… They took an instant dislike to me [because of] my appearance and made comments stating I was a princess and spoilt. They treated other students and team members with… respect, however I did not receive any of this".[32]

Other forms of incivility include physical threats and sexual harassment. Two studies described the examples of nursing students being stalked and having an inappropriately touching by staff.[22, 34] Worryingly, some nursing students had experienced different forms of physical threats such as nurse instructor throwing items (patient file folders, intravenous fluid bags, and key) at students.[22, 25, 33, 34]

Synthesized finding 3

Faculty incivility in the clinical education context not only has a huge physical and emotional impact on nursing students but also influences the process of professional formation.

This synthesized finding was originated from eight findings and grouped into three categories. Studies described the impact of perceiving incivility from faculty included having negative emotions, having physical symptoms, and questioning the nursing profession. Feeling helplessness, hopelessness and powerlessness is the most common emotional response noted by participants.[15, 24, 26, 28, 31] Other negative emotions included loss of self-esteem, worth and confidence, stress, depression, fear, anger, upset, and anxiety.[22-25, 27, 28, 31, 32, 34, 35] Some students described they had a suicidal tendency seriously and wanted to conduct self-injury to escape from clinical eucation.[22]

> *"I realized that no matter how hard we worked in our clinical group, that it was the instructor's way or no way. It wasn't our work we were being evaluated on; it was our ability to please her. If we didn't look good, she didn't look good. If we embarrassed her, she would squash us, she would fail us. We felt helpless".*[24]

The consequence of incivility included suffering from physical symptoms. These reactions included sleep disorders, fatigue, sweating, nausea, vomit, headaches, chest pain, nervousness, palpitations, cardiac and abdominal symptoms, overeating or appetite loss.[22, 24, 28, 31, 32, 35] In addition, incivility also caused issues with loss of motivation, productivity, and performance.[28, 31, 34, 35] Students' professional engagement was negatively affected by incivility. In nine studies, nursing students expressed incivility as the criticism of clinical education and nursing profession, and doubt towards their career choice.[16, 22, 23, 25, 27, 28, 31, 32, 34, 35]

> *"I am making it my duty as a registered nurse to never forget how it felt as a student that was bullied on placement".*[22]
>
> *"Bullying has totally eroded the credibility of the profession in my eyes".*[28]

Synthesized finding 4

Facing faculty incivility in the clinical context, nursing students can develop either negative or positive coping strategies to accept the harsh realities of life or fighting incivility.

This synthesized finding was originated from 15 findings and grouped into two categories. Studies noted that nursing students developed different responses to incivility when they perceived uncivil treatment through their education. Three subthemes were categorized including negative coping, positive coping, and seeding the future. Nine studies described negative coping strategies. Students often felt powerless to deal with incivility and the most common way of responding was by removing themselves from the situation.[26, 34] Students were reluctant to report the incidences of perceiving incivility and felt it unlikely to lead to change.[15, 16, 22, 25, 26, 31, 37] They accepted the harsh clinical education as a part of student life.[31] However, some nursing students chose to change their major and left the nursing program.[24]

> *"'We have to get used to verbal abuse incidents like this. Ultimately, we have to accept the clinical reality. The most important goal is to graduate. My mother is my best counsel'. She keeps saying, 'Be patient! It will come to an end'".*[31]

Eleven studies noted that nursing students confronted incivility by using positive coping strategies. Positive strategies including standing up to report the incivility they perceived to high level;[16, 22, 24, 30, 31, 35] improving communication with the medical staff;[16, 26, 31, 35, 36] sharing the story with their families and friends;[24, 25, 28, 31, 36] seeking support from other nice nurse faculties and trusted university staff;[24, 25] sharing the experience in end-of-semester evaluations;[35] trying to understand from staff's viewpoint;[36] developing self-resilience;[22, 26] maintaining self-values and restoring confidence.[23, 36] Many nursing students who had perceived incivility once noted that they would not being disrespectful to the students in the future.[22, 26]

> *"Spent the afternoon shadowing a 2nd-year student. She was really helpful and friendly. I found it reassuring that she had experienced the same anxieties and fears".*[36]

> *"I am making it my duty as a registered nurse to never forget how it felt as a student that was bullied on placement... I was shocked that nurses − [supposedly] such a caring profession − could be so ruthless towards students. I think bullying in nursing really needs to stop".*[22]

Synthesized finding 5

Students' individual, staff, and clinical culture factors place nursing students at risk for incivility. These factors work individually or collectively.

This synthesized finding was originated from 15 findings and grouped into three categories. While there is absolutely no excuse for medical staff to harass and humiliate nursing students, most incivilities have underlying reasons that lead them to this behavior. The possible reasons were categorized into staff-related reason, student-related reason, and culture. Staff-related factors were identified as the main trigger for incivility, including: conflicts among staff;[29] having work overload and workplace stressor;[15, 34-36] having personal life stressor;[35] previous having encounters with students;[35] limited availability of instructor;[15] limited competency;[15] individuals' characteristics and personalities;[35] having misperceptions about university education;[31, 35] and having generation gap.[32, 34]

> *"It is like a lot of the time the nurses are overwhelmed. They have six or seven patients instead of the four that they should have and...they convey their stress on to people. They put it onto others—and it turns into bullying, but it's really you know 'I feel overworked' or 'I'm too told to be in this position' or 'I can't lift like I [used] to".*[34]

According to students- related factors, incivility is a mutual conflict which depends on how well nursing students respected their clinical instructor. Nursing student showing less respect to their instructors was the common trigger for incivility.[21] Of note, two studies noted that students' youth, gender, personalities, and inexperience in the work environment increased their risk of being subjected to incivility.[31, 35] On the other hand, nursing students were the vulnerable population in the clinical environment, which made them easily being targeted and crushed.[22]

Clinical culture is another factor that contributes to the incivility for nursing student. Particularly, included studies showed that bully was a rite of passage of culture transition from school to the new hierarchical environment.[22, 23, 25, 29, 34] One study showed a "student not welcome" culture in the clinical setting could also create incivilities.[34]

> *"Some nurses are very nice to students and very helpful and others you get the vibe you know they don't want you there".*[34]

Synthesized finding 6

Both university and hospital can consistently respond to faculty incivility in clinical education towards nursing students. Building an anti-incivility environment needs university and hospital working together.

This synthesized finding was originated from eight findings and grouped into two categories. The last synthesized finding describes the suggestions from nursing students to universities and to hospitals. Suggestions to universities can be categorized into four sectors:[25, 34] educating and preparing students responses to incivility; having an immediate response person or system; having faculties to follow up and to keep monitoring; having peer support and other opportunities.

> *"The university should have an immediate response person or system to ensure immediate support. We need a phone number or email for help and advice straight away, like you can call and say this has happened".*[25]

Suggestions to hospitals can be categorized into four factors:[23, 31, 34] qualifying preceptors and keeping continuous evaluation; having a perceived authority of instructors; clarifying the roles of students; establishing positive professional role model.

> *"Those nurses are acting as teachers and some people weren't meant to be teachers. They may be good nurses but they're not good teachers, and they need to think about that more in terms of who they're assigning and make the compensation for it so they want to do it, the ones who are good at it want to do it. It should be a regular thing where they're evaluated on it".*[34]

ConQual summary of synthesized findings

ConQual scores and summary of synthesized findings is summarized in Table 4. Confidence is low for six synthesized findings. Downgraded one level was due to dependability limitation issues. Mix of unequivocal and credible findings was another reason to downgrade credibility of all included studies

Discussion

Our systematic review and meta-synthesis provided a comprehensive picture of nursing students' experience with faculty incivility in the available literature. Based on the exhaustive search strategies, eighteen studies were included. Six synthesized findings were identified, covering features of incivility, manifestations of incivility, contributing factors, impacts on students, coping strategies, and suggestions.

The meta-synthesis revealed that in addition to disrespect, feeling of being unwanted and ignored, inequality, lack of professionalism was identified as an important display of workplace incivility. This finding added to our knowledge that nursing students regarded instructors acted without professionalism as incivility to them, which was different from the faculty-to-faculty incivility. In the clinical education setting, nursing students still expect preceptors to be role models and demonstrate positive and constructive manners.[38, 39] Even working with medical teams, most nursing students are still subject to a structured academic setting and in the transition from a student to a nurse.[40, 41] Therefore, nursing student orientation decides they will use a same evaluation standard to measure the behaviors of clinical preceptors as academic faculty. This result indicates that a qualification assessment and training are essential for clinical nurse preceptors.

Our study also showed that the impact of incivility is very far-reaching. Students who perceived such incivility at work would not only bring home the negative emotions but also would lose motivation in the next few days and doubt profession choice in the future. Clinical education is the first time for nursing student transit from learning in classrooms to studying in real care environments. Previous studies already showed clinical education was the crucial period for nursing student to cultivate professionalism.[10, 11] The experience students perceived is highly associated with job satisfaction and

turnover intention.[42] Therefore, incivility is the barrier to the professional formation and will make the shortage of nurses even worse. Incivility in the nursing clinical education program is particularly crucial in the time of global critical nursing shortages worldwide. Universities and hospitals have an ethical mandate to ensure nursing students, and preceptors, are practicing in areas that don't negatively influence student health and help students to form professionalism.

Different from previous discoveries, our study showed many nursing students adopted positive strategies to cope with incivility. Previous studies noted that students tend to use avoidant strategies when facing uncivil behaviors. Using negative coping strategies may contribute to increased emotional burden, being the target of incivility, and holding a grudge against victimizer.[43] Nevertheless, in recent years, series anti-bully campaigns have been popping up everywhere in response to the situation of uncivil behaviors in the schools. Standing out to end bully become the trends among students.[44] Some studies believed it is the best if students can come to a resolution between you and the person exhibiting incivility. However, unlike facing the bully, dealing incivility directly with the person might not be a good option. Incivility manifests as a rude or disrespectful action that is difficult to invoke adverse management actions from organization levels. In our study, seeking help from trusted person and organization was the most common strategy used by nursing student. Using indirect confrontation coping strategies can elicit positive results for students such as accommodating negative emotions which is beneficial to build a good interpersonal work relationships.[24, 25, 45] Additionally, these strategies can protect the victims in the hierarchical system.[31, 35] Therefore, it is crucial for hospitals or universities to have an immediate response person or system to help nursing students confronting incivility and to follow up and monitor the development.

We found work overload and job stress were important factors contributing to incivility. This is similar to previous studies showed work overload may increase employee's tendency to display uncivil manners and made them had no time to be nice.[46] There is a significant relationship among workplace incivility, job stress and turnover intention.[47] The consequences of overload and unmanaged stress are the dance of civility. Stress stemming from incivility can also silently kill productivity and staff/students. The vicious cycle of "overload work–work stress- incivility" should be broken. Self-monitoring is an important process for medical staff to detect, reflect and assess their own

behavior. Especially, preceptors need to know what are the emotional triggers and how to curb negative responses. Nurse leaders can provide stress-reducing interventions to lead organizational cultural be a more open communication environment and have less incidence of workplace incivility.

Another issue needs to be considered when interpreting our findings. The levels of confidence across six synthesized findings were downgraded due to the dependability issue and a mix of unequivocal and credible findings. Among 18 included studies, the majority did not report authors' influence (e.g. roles, beliefs, and value) on the studies, which influenced the dependability of all synthesized findings. It is recommended that future studies need to strengthen the methodological quality of qualitative studies and add credibility to the research findings.

The strength of this study is that we performed a comprehensive search strategy to find all relevant studies in nine academic databases and four grey literature databases. Both journal articles and thesis were included in order to provide an unbiased result. Another strength is that we used JBI meta-aggregation method to synthesize qualitative data, which avoided re-interpreting of original studies. Finally, to our knowledge, there is no qualitative systematic review on this topic.

Limitations

Our studies also have limitations. First, as with all meta-syntheses, the findings are limited by the study quality and the interpretations of the original researchers. Additionally, we only included studies in English. All the included studies were conducted in the United States, European countries and Australia. Cultural variation may have variation in individual responses to incivility. Therefore, the findings only can be generalized to other contexts with a similar culture.

Conclusions

This study synthesized the qualitative evidence on the experiences and perceptions of incivility in the clinical education of nursing students, and evaluated the influence of incivility on student nurses. The findings showed the experience of incivility in clinical education was common and had negative impacts on nursing students and nurse profession. We suggest nursing students try to cope with incivility positively. Nurse managers and clinical preceptors should have the awareness of the

prevalence and impact of incivility, and implement policies and strategies to reduce incivility for nursing students. Hospitals and universities need to have an immediate response person or system to help nursing students confronting incivility, and create an open communication environment.

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Author Contributions

Study design: XWJ; Data collection and appraisal: ZZ, XWJ; Data analysis: ZZ, XWJ; Study supervision: HY; Manuscript writing: ZZ, XWJ; Critical revisions for important intellectual content: LL, HY, GMD. All authors revised and accepted the final draft.

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Conflicts of Interests

The authors report no real or perceived interests that relate to this article that could be construed as a conflict of interest.

Data Share Statement

No additional data are available

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Table 1. Results of quality assessment based on JBI critical appraisal checklist for qualitative studies*

	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10
1. Altmiller (2012)[15]	U	U	Y	Y	Y	U	U	U	U	Y
2. Anthony (2011)[16]	U	U	Y	Y	Y	U	U	Y	Y	Y
3. Birks et al. (2017)[22]	U	Y	Y	Y	Y	U	U	Y	Y	Y
4. Cantey (2012)[23]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5. Clark (2008)[24]	U	Y	Y	Y	Y	U	U	Y	Y	Y
6. Courtney-Pratt et al. (2017)[25]	U	Y	Y	Y	Y	U	U	Y	Y	Y
7. Curtis et al. (2007)[26]	U	Y	Y	Y	Y	U	U	Y	Y	Y
8. Del Prato (2013)[27]	U	Y	Y	Y	Y	U	U	Y	Y	Y
9. Hakojarvi et al. (2014)	U	Y	Y	Y	Y	U	U	Y	Y	Y
10. Hoel et al. (2007)[29]	U	U	Y	Y	U	U	U	Y	U	Y
11. Jackson et al. (2011)[30]	U	Y	Y	Y	Y	U	U	Y	Y	Y
12. Lash et al. (2006)[31]	U	Y	Y	Y	Y	U	U	Y	Y	Y
13. Martel (2015)[32]	Y	Y	Y	Y	Y	U	Y	Y	Y	Y
14. Rees et al. (2015)[33]	Y	Y	Y	Y	Y	U	U	Y	Y	Y
15. Smith et al. (2016)[34]	U	Y	Y	Y	Y	U	U	Y	Y	Y
16. Thomas (2015)[35]	Y	Y	Y	Y	Y	U	Y	Y	Y	Y
17. Thomas et al. (2015)[36]	U	Y	Y	Y	Y	U	U	Y	Y	Y
18. Thomas & Burk (2009)[37]	U	U	Y	Y	Y	U	U	Y	Y	Y

*C1= Congruity between the stated philosophical perspective and the research methodology;
C2= Congruity between the research methodology and the research question or objectives
C3= Congruity between the research methodology and the methods used to collect data
C4= Congruity between the research methodology and the representation and analysis of data
C5= There is congruence between the research methodology and the interpretation of results
C6= Locating the researcher culturally or theoretically
C7= Influence of the researcher on the research
C8= Representation of participants and their voices
C9= Ethical approval by an appropriate body
C10= Relationship of conclusions to analysis, or interpretation of the data
Y= Yes; N=No; U=Unclear; NA=Not applicable

Table 2. Characteristics of the studies

Study (Year), Country	Design (Method of data collection)	Interest of phenomenon	Recruitment and participants	Main findings
Altmiller (2012), US[15]	Phenomenology (focus group interview)	To describe the phenomenon of incivility in undergraduate nursing program.	Four universities in US; Twenty-four undergraduate junior and senior nursing students	Nine themes were identified in this study: unprofessional behavior, poor communication techniques, power gradient, inequality, loss of control over one's world, stressful clinical environment, authority failure, difficult peer behaviors, and students' view of faculty perceptions
Anthony (2011), US[16]	Descriptive qualitative study (focus group interview)	To describe the student experiences and perceptions of the incivility in the clinical education.	One nursing school in US; Twenty-one nursing students	The experience of perceived incivility categorized into three themes: 1) exclusionary; 2) hostile or rude, and 3) dismissive. Positive experiences could be felt when the students was welcomed by the staff.
Birks et al. (2017), Australia[22]	Descriptive qualitative study (open-ended questionnaire)	To describe experienced of bullying and harassment among nursing students in the clinical education.	An online platform in Australia; Four hundred and thirty nursing students	Three themes derived from the analysis: manifestations of bullying and harassment, the perpetrators, consequences and impacts.
Cantey (2012), US[23]	Narrative inquiry (semi-structured interview)	To explore the experience of vertical violence among registered nurses during school nurses' clinical education.	One generic class in US Four registered nursing students	Three themes were gleamed from the analysis of data: Rite of Passage; Professional Identity Development, Positive Professional Role Model.
Clark (2008), US[24]	Phenomenology (semi-structured interview)	To describe the nursing students experience of uncivil encounters with nursing faculty.	Four nursing schools in the US; Seven current and former nursing students	Three major themes were identified regarding to incivility conducted by faculty: 1) behaving in demeaning and belittling ways, 2) treating students unfairly and subjectively, and 3) pressuring students to conform to unreasonable faculty demands. Three major themes were identified regarding to students' emotional responses: 1) feeling traumatized, 2) feeling powerless and helpless, and 3) feeling angry and upset.
Courtney-Pratt et al.	Mix-methods	To explore nursing students' experiences about bullying	One Australian university;	Four themes were derived from the analysis: 1) Manifestations of

(2017), Australia[25]	(semi-structured interviews)	in clinical and academic settings.	Twenty-nine first-, second- and third-year undergraduate nursing students	bullying in clinical settings and academic setting; 2) impact of experiences on students, strategies students used to "make sense of" and address bullying, 3) recommendations from students on how to prepare for; and 4) manage bullying.
Curtis et al. (2007), Australia[26]	Descriptive qualitative study (open-ended questionnaire)	To investigate the nursing students' experiences of horizontal violence in nursing workplace in Australia.	One university in Australia; One hundred and fifty-two second- and third- year nursing students	Five major themes were identified: 1) humiliation and lack of respect; 2) powerlessness and becoming invisible; 3) hierarchical nature of horizontal violence; 4) coping strategies; and 5) future employment choices.
Del Prato (2013), US[27]	Phenomenology (In-depth interviews)	To understand the students' experience of faculty incivility in associate degree nursing education.	One university in US; Thirteen nursing students from three associate degree nursing education programs	Faculty incivility categorized into four themes: 1) demeaning experiences; 2) subjective evaluation; 3) rigid expectations, and 4) targeting and weeding out practices.
Hakojarvi et al. (2014), Finland[28]	Descriptive study (an electronic semi-structured questionnaire)	To describe health care students' (including nursing students) personal experiences of the bullying by the staff or clinical instructors in clinical settings.	Two university in Finland; Forty-one health care students from	1) Students experienced both verbal and non-verbal bullying in the clinical training. 2) Bullying influenced the students' motivation and professional engagement. 3) Some students thought it was useless to share with the experience with their teacher and instructors. However, those students who shared the bullying experience received emotion support and information.
Hoel et al. (2007), UK[29]	Not specified (focus group interview & one-to-one interview)	To explore nursing students' experiences and perceptions of bullying in clinical setting.	Recruited from universities and an advertisement in UK Forty-eight nursing students	1) Students felt exploited, ignored and unwelcome. 2) Bullying experiences had strong effect on the institutionalizing an unwelcoming culture in the clinical setting. 3) Students 'coping mechanisms contributed to reproducing negative behaviors toward to them.
Jackson et al. (2011),	Not specified	To explore undergraduate students' experiences of	An online website in Australia;	Three themes were categorized: 1) Confronted by contradiction:

Australia[30]	(open-ended questionnaire)	negative behaviors in the clinical settings.	One hundred and five nursing students from a large Australian university	students as 'Other'; 2) Organizational aggression as a legitimating device; 3) Resisting 'othering': securing a legitimate identity as a student
Lash et al. (2006), Turkey[31]	Phenomenology (focus group interview)	To describe nursing and midwifery students' experiences with perceived verbal abuse in clinical settings in Turkey.	One university in Turkey; Seventy-three nursing and midwifery students	Four categories were derived from interviews: 1) experiences of verbal abuse; 2) perceptions of the effects of verbal abuse; 3) ways of coping with verbal abuse; 4) recommendations to prevent and effectively respond
Martel (2015), UK[32]	Phenomenology (semi-structured interviews)	To describe the experience of nursing students about nursing staff's incivility.	One university in UK; Seven BSN students	Uncivil behaviors deprived into three themes: 1) lack of receptiveness; 2) belittling; and 3) failing to recognize the assistance of students. Consequence of uncivil behaviors including: emotional hurt, loss of confidence, discouragement, fear, demotivation, and unhappiness
Rees et al. (2015), UK[33]	Not specified (individual and group interviews)	To explores dental, nursing, pharmacy and physiotherapy students' experiences about workplace abuse.	Three universities in UK; Sixty-nine healthcare students (n=13 nursing students)	1) Covert abuse was the most reported type of abuse in the narratives; 2) Individual, relational, work and organizational factors contributed to abuse. The perpetrators was the most important factors; 3) Most participants acted in the face of their abuse; d) Perpetrator-recipient relationship is the main contributory factor.
Smith et al. (2016), US[34]	Descriptive qualitative study (focus group interview)	To explore what types of bullying behaviors nursing students encountered in the clinical replacement and how these encounters impacted them.	Four colleges in US; Fifty-six undergraduate nursing students	Four categories were identified: 1) bullying behaviors; 2) rationale for bullying; 3) response to bullying, and 4) recommendations to address bullying.
Thomas (2015), US[35]	Phenomenology (semi-structured interviews)	To understand the nursing students' experience of incivility in a clinical education setting	One university in US; Twelve junior and senior nursing students in a baccalaureate nursing program	Nursing students felt unprepared to effectively respond when encountering incivility and experienced emotional and behavioral harm from the encounters.
Thomas et al. (2015), UK[36]	The classic grounded theory (diary)	To explore the impacts of the first clinical placement on the professional socialization of adult undergraduate	Twenty-six undergraduate adult student nurses in UK	Incivility is comprised of three stages including: 1) stage of dislocation (disillusionment with role, needing benevolence, and

		student nurses in the UK.		being altruistic); 2) stage of status negotiation (significant others, seeking recompense, and brokering for learning); 3) stage of status relocation (being benevolent, maintaining values, and recanting status).
Thomas & Burk (2009), US[37]	Descriptive study (story written)	To explore the experience of injustice perpetrated by staff RNs during nursing students' clinical replacement.	One university in US; Two hundred and twenty-one junior nursing students	Four levels of injustice were described: 1)"We Were Unwanted and Ignored"; 2) "Our Assessments Were Distrusted and Disbelieved"; 3)"We Were Unfairly Blamed"; and 4)"I Was Publicly Humiliated"

657 **Table 3**. Synthesized Findings

Findings	Categories	Synthesized Findings
Diverse, overt and covert, verbal and non-verbal (U) Unavoidable, unprepared, pervasive and recurring (U) Ongoing and endless, continued in professional lives (U) Multiple perpetrators, clinical instructors, other nurse staff, Physicians, healthcare assistants, ward cleaner (U) Being difficult to prove (U) Hierarchical (C)	Feature/nature of incivility	1. There are different types of incivility that can be experienced by nursing students. Some are noticeable while others can be more subtle which are hard to be proved. Most of the nursing students are unprepared for the incivility from multiple perpetrators.
Failed to provide learning opportunities or guidance (U) Rigid expectations for students' abilities (U) Excessive use of students for legwork or own gains (U) Arbitrary changes in syllabi, assignment and schedule (U) Being questioned inadequately (C) Constant criticism and negative feedback (U) Not protecting students for safety (U)	Lack of professionalism	2. Faculty incivility in the clinical education context toward nursing students manifests as lack of professionalism in the workplace, being unrespect and unfair toward nursing students, and letting nursing students feel unwanted and ignored in the workplace. What's worse, some manifestations including physical abuse and sexual harassment violate the law
Belittlement (U) Condescending (U) Be intimidated (U) Personality criticism (C) Humiliation in front of staff and patients (U) Talking about students behind backs (U) Being called derogatory names (U) Being shouted at (U) Hostile body language (eyeing rolling, without eye contact) (U)	unrespect	
Feeling like a nuisance (U) Not being involved into nursing activities (U) Refusal to answer, help or support (U) Not being permitted to use staff room (U)	unwanted and ignored	
Favoritism (U) Being targeted or retaliation (U) Racial/ethnic bias (U) Gender bias (U) Appearance bias (U) Subjective evaluation (U)	inequality	
Physical abuse (U) Sexual harassment (U)	Other manifestations which violate the law	
Helplessness/hopelessness/powerlessness (U) Loss of self-esteem, worth and confidence (U) Stress, depression, distress, fear, anger, upset, anxiety (U) Suicidal, self-harm (C)	Psychological symptoms	3. Faculty incivility in the clinical education context not only has a huge physical and emotional impact on nursing students but also influences the process of professional formation.
Sleep disorders, fatigue, sweating, tearfulness, nausea, vomit, headaches, chest pain , palpitations, cardiac and abdominal symptoms, overeating or appetite loss (U)	Physical symptoms	

Deleterious consequences for patients (C) Doubting profession choice and having the desire to quit nursing (U) Loss of motivation, productivity and performance (U)	Professional formation	
Tolerated and reticent to report (U) Becoming invisible (U) Accepting as a part of student life (U) Leaving nursing program (U)	Negative coping	4. Facing faculty incivility in the clinical context, nursing students can develop either negative or positive coping strategies to accept the harsh realities of life or fighting incivility.
Standing up to report (U) Improving communication with staff (U) Sharing with families and friends (U) Seeking support from nice nurse faculty (U) Seeking advice from trusted university staff (U) Sharing in end-of-semester evaluations (U) Trying to understand from staff's viewpoint (U) Developing self-resilience (C) Maintaining self-values and restoring confidence (U) Standing up to report (U) Being benevolent and would not perpetuate incivility (U)	Positive Coping	
Conflicts among staff (U) Workplace stressors and overload (U) Personal life stressor (U) Previous bad encounters with students (U) Limited availability of instructor (U) Limited competency (U) Characteristics and personalities (U) Misperceptions about university education (U) Generation gap (C)	staff-related factors	5. Students' individual, staff, and clinical culture factors place nursing students at risk for incivility. These factors work individually or collectively,
Showing less respect (U) Limited power (C) Youth, gender and inexperience (U) Characteristics and personalities (U)	Students-related factors	
Rite of passage/vicious cycle (U) The culture of "students not welcome" (U)	Culture-related factors	
Educate and prepare students responses to incivility (U) Immediate response person or system (U) Faculty follow up and monitor (U) Peer support and opportunities (U)	Suggestions to university	6. Both university and hospital can consistently respond to faculty incivility in clinical education towards nursing students. Building an anti-incivility environment needs university and hospital working together.
Qualifications of preceptors and continuous evaluation (U) Having a perceived authority of instructors (C) Clarifying the role of nursing students (U) Positive professional role model (C)	Suggestions to hospital	

658
659

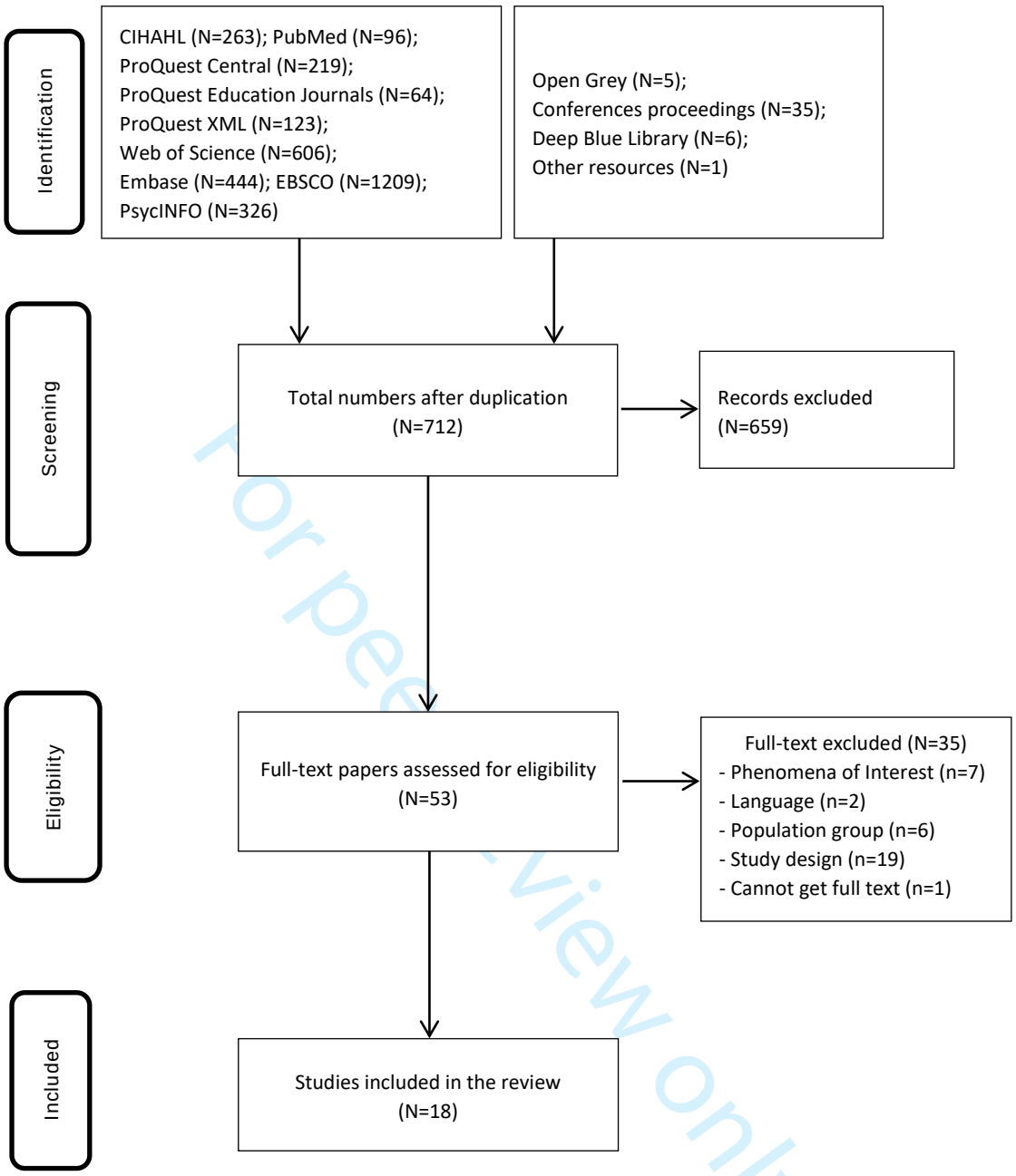
Table 4. ConQual Summary of findings

Synthesized Findings	Type of Research	Dependability	Credibility	ConQual Score
1. There are different types of incivility that can be experienced by nursing students. Some are noticeable while others can be more subtle which are hard to be proved. Most of the nursing students are unprepared for the incivility from multiple perpetrators.	Qualitative	Downgrade 1 level	Downgrade 1 level	Low
2. Faculty incivility in the clinical education context toward nursing students manifests as lack of professionalism in the workplace, being unrespect and unfair toward nursing students, and letting nursing students feel unwanted and ignored in the workplace. What's worse, some manifestations including physical abuse and sexual harassment violate the law	Qualitative	Downgrade 1 level	Downgrade 1 level	Low
3. Faculty incivility in the clinical education context not only has a huge physical and emotional impact on nursing students but also influences the process of professional formation.	Qualitative	Downgrade 1 level	Downgrade 1 level	Low
4. Facing faculty incivility in the clinical context, nursing students can develop either negative or positive coping strategies to accept the harsh realities of life or fighting incivility.	Qualitative	Downgrade 1 level	Downgrade 1 level	Low
5. Students' individual, staff, and clinical culture factors place nursing students at risk for incivility. These factors work individually or collectively,	Qualitative	Downgrade 1 level	Downgrade 1 level	Low
6. Both university and hospital can consistently respond to faculty incivility in clinical education towards nursing students. Building an anti-incivility environment needs university and hospital working together.	Qualitative	Downgrade 1 level	Downgrade 1 level	Low

Figure 1 Flow chart of the search strategy and results

Appendix I the ENTREQ statement

Appendix II: Search strategy for PubMed (MEDLINE)



Appendix I the ENTREQ statement

Section/topic	#	Checklist item	Reported on Page #
Aim	1	State the research question the synthesis addresses.	P5
Synthesis methodology	2	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	P5
Approach to searching	3	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved).	P6
Inclusion criteria	4	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).	P6
Data sources	5	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organizational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources.	P6
Electronic Search strategy	6	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits).	P6 & Appendix II.
Study screening methods	7	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies).	Fig. 1
Study characteristics	8	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	Table 2
Study selection results	9	Identify the number of studies screened and provide reasons for study exclusion (e,g, for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).	Fig. 1

Rationale for appraisal	10	Rationale for appraisal	P6
Appraisal items	11	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	Table 1
Appraisal process	12	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	P6
Appraisal results	13	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	Table 1
Data extraction	14	Indicate which sections of the primary studies were analyzed and how were the data extracted from the primary studies? (e.g. all text under the headings “results /conclusions” were extracted electronically and entered into a computer software).	P7
Software	15	State the computer software used, if any.	P7
Number of reviewers	16	Identify who was involved in coding and analysis.	P7
Coding	17	Describe the process for coding of data (e.g. line by line coding to search for concepts).	P7
Study comparison	18	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	P7
Derivation of themes	19	Explain whether the process of deriving the themes or constructs was inductive or deductive.	P7
Quotations	20	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author’s interpretation.	P10-P17
Synthesis output	21	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	P10-P17

Appendix II: Search strategy for PubMed (MEDLINE)

Date: 2018.01.06

Database: PubMed (MEDLINE)

Set #		Results
1	incivility [MeSH] OR bullying[MeSH] OR "workplace violence" [MeSH] OR incivilit*[tiab] OR bully[tiab] OR uncivil[tiab] or aggression*[tiab] or harass* [tiab] OR mob [tiab] mobs [tiab] OR mobbing [tiab] OR victimiz* [tiab] OR ill-treat*[tiab] or abuse*[tiab] OR [tiab] OR oppress*[tiab] OR " horizontal violence"[tiab] OR "lateral violence" [tiab] OR disruptive[tiab] OR mistreat*[tiab] OR dilemma*[tiab] OR distress*[tiab] OR violen*[tiab] OR "nurses eat their young"[tiab]	12207
2	nurse [MeSH] OR nurs*[tiab] OR health[tiab]	442373
3	student[MeSH] OR student*[tiab] OR undergraduate* [tiab] OR graduate* [tiab]	298999
4	Hospitals[MeSH] OR workplace[MeSH] OR Hospital*[tiab] OR clinic [tiab] clinical [tiab] OR workplace*[tiab] OR work[tiab] OR "job site*" [tiab]	1144910
5	#1 AND #2 AND #3	96

Nursing students' experiences with faculty incivility in a clinical education context: A qualitative systematic review and meta-synthesis

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Nursing students' experiences with faculty incivility in clinical education context: A qualitative systematic review and meta-synthesis

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Abstract

Objective: The aim of this study is to synthesize evidence for the experiences and perceptions of incivility during the clinical education of nursing students.

Design: We used a meta-aggregation approach to conduct a systematic review of qualitative studies.

Data sources: Published and unpublished papers from 1990 until 13 January 2018 were searched using electronic databases, including CINAHL, PubMed (MEDLINE), ProQuest Central, ProQuest Education Journals, ProQuest XML-Dissertations and Theses, Web of Science, Embase, EBSCO Discovery Service and PsycINFO. The search for unpublished studies included the Open Grey collection, conference proceedings, and the Deep Blue Library.

Eligibility criteria: We included qualitative studies that focused on nursing students' perceptions and experiences of incivility from faculty during their clinical education.

Data extraction and synthesis: Two reviewers independently appraised the methodological quality and extracted relevant data from each included study. Meta-aggregation was used to synthesize the data.

Results: A total of 3397 studies were returned from the search strategies. Eighteen studies fulfilled the inclusion criteria and were included in the meta-synthesis. Six synthesized findings were identified, covering features of incivility, manifestations of incivility, contributing factors, impacts on students, coping strategies, and suggestions.

Conclusions:

The results showed experiences of incivility during clinical education. However, the confidence was low for all synthesized findings. We suggest that nursing students should try to cope positively with incivility. Nurse managers and clinical preceptors should be aware of the prevalence and impact of incivility and implement policies and strategies to reduce incivility towards nursing students. Hospitals and universities should have an immediate response person or system to help nursing students confronting incivility and create an open communication environment.

Keywords: Nurse education; Incivility; Systematic review; Meta-synthesis

Strengths and limitations of this study

- We used the JBI meta-aggregation method to synthesize qualitative data, which minimized re-interpretation of original studies.
- We performed a comprehensive search strategy to find all relevant studies in nine academic databases and four grey literature databases.
- Both published articles and theses were included to provide unbiased results.
- We only included studies in English. All included studies were conducted in the United States, European countries and Australia. Cultural variation may have accounted for individual responses to incivility.

Introduction

Incivility is defined as a rude and deviant act characterized by low-intensity discourteous behaviour with or without intent to harm, offend and humiliate the target.[1, 2] For decades, nurse-to-student incivility has been prevalent in clinical settings. The unfortunate idiom "nurses eat their young" has been used for more than 30 years.[3] Previous studies showed that nursing students had experiences of being bullied, harassed and unfairly blamed by clinical faculty. The results from a study conducted by Clark and Springer revealed that over 70% of 356 respondents believed that incivility in nursing education was a moderate or serious problem and had increased over the last five years.[4] A survey conducted in Oman showed over 40% of the respondents experienced different forms of incivility, including being disrespectful, being unprepared for class, and cancelling scheduled activities without warning.[5] The literature suggests that several key factors contribute to incivility.

Rowland and Srisukho found that gender, class standing, average grade, informal interactions between faculty and students, and academic achievement were the key factors associated with incivility towards students.[6] Vink et al. indicated that factors contributing to incivility could be categorized into three themes (academic, psycho-pathological, and social factors).[7] Other factors identified by previous studies included policies on uncivil behaviours, the political atmosphere, and environmental factors.[8, 9]

In the face of high rates of nurse turnover and workforce attrition in nursing, nurse educators and managers have realized that incivility in clinical settings can be contributory because it can harm both individuals and their organizations. Anthony et al. and Kinley found that incivility could negatively influence students' confidence, make them question whether they were completely incompetent as a nurse, and lead to a high level of turnover among new graduate nurses during their first two years of employment.[10, 11] The studies conducted by Seibel and Milesky et al. showed that victims of incivility suffered from physical and emotional distress that affected patient care and was related to patient safety.[12, 13] The report from the Joint Commission showed that uncivil behaviour in the health care setting could lead to medical errors, poor clinical outcomes, low patient satisfaction, and increased costs of care.[14]

Nursing faculty incivility in clinical education has also been reported in the literature. Altmiller and Anthony and Yastik conducted focus group interviews to describe the phenomenon of incivility in undergraduate nursing programmes.[15, 16] Although the qualitative research yielded in-depth information from a small sample of participants, the external validity and transferability of results from a single study were still limited. A variety of aspects of the experience of faculty incivility need to be integrated to produce more robust evidence across multiple qualitative studies. Obtaining a deep understanding of the phenomenon is necessary for the use of mindfulness solutions to inform the practice and transform the culture of the workplace. To obtain a comprehensive picture of this phenomenon, we used the meta-synthesis approach to manage and report findings from multiple qualitative research studies.[17]

The aim of this study is to synthesize evidence based on the experiences and perceptions of nursing students regarding incivility in clinical education. Specifically, the review addressed the following research questions: 1) What behaviour in the clinical environment did the student consider uncivil? 2) To what extent did these behaviours affect them? 3) What strategies did they use to cope with incivility?

Methods

We used a meta-aggregation approach to conduct a systematic review of qualitative studies following the Enhancing Transparency in Reporting the Synthesis of Qualitative research (ENTREQ) statement (Appendix I).[18]

Inclusion criteria

The inclusion criteria included the following: 1) the participants were current nursing students undergoing clinical education or had already completed their clinical education; 2) the phenomena of interest focused on the perceptions and experiences of incivility from faculty during clinical education; 3) context: faculty incivility must have occurred in clinical settings or during clinical education; 4) qualitative studies including but not limited to ethnographies, phenomenologies, narrative studies, grounded theory, and case

studies; additionally, mixed-method studies with a narrative description of faculty or student voices describing the phenomena under study were also considered; and 5) studies published in English.

Search strategy

We included both published and unpublished papers. A three-step search approach was conducted in this study. First, we searched MEDLINE (via PubMed) to analyse the text words and the index terms that could be used in the comprehensive search. Second, a comprehensive search was conducted across all included databases using keywords and index terms. The databases included CINAHL, PubMed (MEDLINE), ProQuest Central, ProQuest Education Journals, ProQuest XML-Dissertations and Theses, Web of Science, Embase, EBSCO Discovery Service and PsycINFO. The search for unpublished studies included the Open Grey collection, conference proceedings, and the Deep Blue Library. Relevant papers published from 1990 until 13 of January 2018 were evaluated. The search terms included nurs* AND (student* OR graduate*) AND (incivilit* OR bully* OR workplace violence OR uncivil OR aggression* OR harass*) AND (hospital* OR clinic* OR workplace*). The search strategy for PubMed (MEDLINE) is available in Appendix II. In the third step, additional studies were searched manually by screening the references of related studies. The search results were imported into Endnote X8 (Clarivate Analytics, Philadelphia, PA), which was used to manage the literature.

Critical appraisal

We used *the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Qualitative Research* to assess the methodological quality of the included studies.[19] This 10-item JBI critical appraisal tool is designed to assess research quality in different domains, including research methodology and conceptual depth of reporting. Two reviewers appraised the methodological quality of each included study independently (ZZ and XWJ). Disagreements were resolved through discussion.

Data extraction

The JBI standardized form was used to extract qualitative data. The data extraction form included the following domains: study (year), country, design (data collection method), phenomenon of interest, recruitment and participants, and main findings including relevant illustrative quotations. Relevant data were extracted independently by two reviewers (ZZ and XWJ). Disagreements were resolved through discussion.

Data synthesis

The JBI meta-aggregation method was used to synthesize the data. Meta-aggregation is one approach that can be used to synthesize qualitative evidence based on the primary author's findings and is a useful method for generating recommendations for action.[19] This approach focuses on integration of findings from processed data rather than raw data collected from participants. The overall goal of meta-aggregation is to produce synthesized findings that are highly relevant for practitioners, patients and policy makers.[19] Data extraction, comparison and synthesis were conducted using JBI-SUMARI.[20] The procedures involved four steps. 1) Thorough repeated reading of the paper, with verbatim statements and accompanying quotations extracted from each study by the primary reviewer (XWJ). Only findings identified as highly correlated with our phenomenon of interest were extracted from each study. To ensure rigor, the second reviewer (ZZ) checked all extractions. 2) Two reviewers (ZZ and XWJ) independently assigned the credibility level for each research finding. All disagreements were resolved through discussion. If more than one quotation was included for the same finding, we assigned the highest level of credibility (unequivocal > credible > unsupported). 3) Findings rated as unequivocal or credible were aggregated into categories based on similar meanings. Findings rated as unsupported were eliminated from the subsequent analysis. The categories were determined by the primary reviewer (XWJ) and affirmed by the second reviewer (ZZ). Disagreements were resolved by consensus. 4) Categories with commonality were further integrated into the synthesized findings by the primary reviewers. The synthesized findings and recommendations were examined by all co-authors involved in nursing education.

Confidence in the findings

The synthesized findings were assessed using the JBI ConQual approach to determine the confidence level.[21] The confidence level was rated high, moderate, low, or very low based on the dependability and credibility of the included study.

The dependability for each included study was determined through evaluation of five criteria from the JBI critical appraisal for qualitative studies. The criteria evaluated whether the research methods were appropriate for the chosen research design. The dependability of the synthesized finding was based on the dependability of the included study. [21]

The credibility of each research finding was determined based on the congruity between the study's interpretation of the findings and the participants' quotations. The credibility level can be unequivocal (U), credible (C), or unsupported (UN). The credibility of each synthesized finding was based on the credibility level of the individual research findings. If not all research findings included in a synthesized finding were unequivocal (U), then the credibility of the synthesized findings was downgraded. [21]

Patient and public involvement

No patients or members of the public were involved in the design of this systematic review.

Results

Literature search

The outcomes of the literature search are outlined in Fig. 1. Initially, a total of 3397 studies was returned from the search strategies. After screening the titles and abstracts, we reduced the number of papers to 53 for full-text evaluation. Subsequently, 18 studies fulfilled the inclusion criteria and were included in the meta-synthesis.[15, 16, 22-37]

Quality assessment

Table 1 summarizes the quality assessment of the 18 selected studies. All 18 studies had similar phenomena of interest, methodologies, and data analysis methods. Only one study reported the potential beliefs and values of the authors that might have influenced the findings.[23] Three studies reported the authors' roles in the study that might have potentially influenced the interpretation of the findings.[23, 32, 35] One study did not provide representations of the participants and their voices.[15] Two studies did not report the ethical approval process.[15, 29] The disagreement rate between the two reviewers was 6.6%.

Study description

The study characteristics are summarized in Table 2. Among the 18 studies, 15 studies were published papers[15, 16, 22, 24-31, 33, 34, 36, 37] and three were PhD theses.[23, 32, 35] Six studies used individual semi-structured or unstructured interviews to collect data, [23-25, 27, 32, 35] four studies used focus group interviews,[15, 16, 31, 34] four studies used open-ended questionnaires,[22, 26, 28, 30] two studies used both individual and group interviews,[29, 33] and two studies collected data from diaries and stories written by nursing students.[36, 37] Most of the included studies were published from 2012 to 2017 (n = 11).[15, 22, 23, 25, 27, 28, 32-36] The studies were conducted in five different countries: the United States (n = 8),[15, 16, 23, 24, 27, 34, 45, 37] the United Kingdom (n = 4),[29, 32, 33, 36] Australia (n = 4),[22, 25, 26, 30] Finland (n=1),[28] and Turkey (n=1).[31] Six studies reported recruitment across multiple universities/hospitals.[15, 24, 28, 29, 33, 34] Two studies recruited participants through online platforms.[22, 30] The total number of nursing students included in this systematic review was 1182. Among all of the participants, 348 participants joined an interview, and 834 participants completed a questionnaire or diary. The sample sized ranged from 4[23] to 430 participants.[22]

Review finding

Eighty findings were retrieved from 18 articles. Six synthesized findings were identified. Of these findings, 70 were rated as unequivocal and 10 as credible. An overview of these synthesized findings is summarized in Table 3.

Synthesized finding 1

Different types of incivility can be experienced by nursing students. Some types are noticeable, whereas others can be more subtle and are difficult to prove. Most nursing students are unprepared for incivility from multiple perpetrators.

This synthesized finding originated from six findings and was grouped into one category. Many of the studies describe the features of the incivility. The nursing students perceived diverse incivilities in the clinical workplace. The forms of incivility could be either overt or covert and verbal or non-verbal.[22, 25] Many nursing students believed that incivility in the clinical workplace was pervasive and recurring and that experiencing incivility during clinical education was unavoidable.[22, 25, 34] One nursing student indicated that incivility was a "rite of passage".[22]

> *"It is a serious issue, more of the bullying occurs from registered nurses, a profession where we are meant to care for one another. They are eating their young and wonder why people want to quit nursing. They forget they were just like us once".*[22]

Because the idea of equality between nursing students and clinical staff did not seem viable, the incivility was apparently ongoing and not a onetime occurrence.[26, 35] In this hierarchical system, nursing students believed that to succeed they had to accept their role as defined by those with power and authority.[15, 26, 35] They described perceiving incivility from multiple perpetrators, including clinical instructors, other nursing staff, physicians, healthcare assistants, and ward cleaners.[22, 28-31, 35] However, the students felt that proving they were being bullied or maltreated was difficult.[28]

Synthesized finding 2

Faculty incivility in the clinical education context toward nursing students manifests as a lack of professionalism in the workplace, being disrespectful and unfair toward nursing students, and making nursing students feel unwanted and ignored in the workplace. Worse, some manifestations, including physical abuse and sexual harassment, violate the law.

This synthesized finding originated from 28 findings and was grouped into five categories. The acts of incivility in clinical education can be categorized into lack of professionalism, being disrespectful, feeling unwanted and ignored, inequality, physical abuse, and sexual harassment.

Nursing students noted a range of manifestations as a lack of professionalism from medical staff, including failing to provide learning opportunities or guidance,[31, 32] having rigid expectations for students' abilities,[22, 24, 27, 33, 37] excessive use of students for legwork or their own gains,[31-33, 37] arbitrary changes in syllabi, assignments and schedules,[24] questioning students inadequately,[35] giving constant criticism and negative feedback,[27,32,35] and not protecting the students' safety.[32]

> *"A nurse said, 'You are wasting your time with care plans. We used to do them, but they do not work.' After hearing this, I lost confidence in my education".*[31]

Fourteen studies noted disrespectful behaviours from the medical staff. Characteristics exemplifying disrespectful behaviour included belittlement,[15, 24, 27, 29, 30, 35, 37] being condescending,[24, 34] intimidation,[27, 33, 34] criticism of personality,[22, 37] humiliation in front of staff and patients,[22, 23, 26-28, 33, 37] talking about students behind their backs,[22] calling students derogatory names,[22, 32-34] shouting at students,[28, 33] and having hostile body language (e.g., eye rolling and avoiding eye contact).[22, 36, 37]

> *"… and then in the end… she just got a bit angry with me sort of in front of the patient. . . and said some things like (coughs) I didn't quite think were acceptable to say in front of the patients… rather than helping me she just got angry with me".*[33]

Twelve studies noted unwanted or ignored behaviours bestowed by medical staff towards nursing students. The forms included making the nursing student feel like a nuisance,[16, 25, 30, 33-37] not letting the students be

involved in nursing activities,[22, 32] refusal to answer, help or support,[15, 22, 30, 32, 33, 35, 37] and not permitting the student to use the staff room.[22, 26]

> *"How wrong I was. I have never felt so unwanted in my life. The nursing staffs made me feel like a complete nuisance…I don't think she even made eye contact with me… She seemed annoyed by my presence… ".*[37]

Inequality for all students was identified as another form of incivility. Bias was commonly based on gender, race, appearance, and behaviours.[15, 22, 24, 27] Some faculty favoured male nursing students and younger nursing students and were more positive in their communications with them.[15, 24] The students with unusual behaviours had more challenges.[25, 30, 31] Some nursing student admitted they feared that they were being targeting and avoided any interaction at all with certain instructors.[15, 27]

> *"On my clinical placement, I was immediately judged by one staff member who continuously embarrassed me… They took an instant dislike to me [because of] my appearance and made comments stating I was a princess and spoilt. They treated other students and team members with… respect, however I did not receive any of this".*[32]

Other forms of incivility include physical threats and sexual harassment. Two studies provided examples of nursing students being stalked and experiencing inappropriate touching by staff.[22, 34] Worryingly, some nursing students experienced different forms of physical threats, such as a nurse instructor throwing items (patient file folders, intravenous fluid bags, and a key) at the students.[22, 25, 33, 34]

Synthesized finding 3

Faculty incivility in the clinical education context not only has a huge physical and emotional impact on nursing students but also influences the professional formation process.

This synthesized finding originated from eight findings and was grouped into three categories. Studies described the impact of perceiving incivility from faculty, including having negative emotions and physical symptoms and questioning the nursing profession. Feelings of helplessness, hopelessness and powerlessness were the most common emotional responses noted by the participants.[15, 24, 26, 28, 31] Other negative emotions included loss of self-esteem, worth and confidence, stress, depression, fear, anger, upset, and anxiety.[22-25, 27, 28, 31, 32, 34, 35] Some students reported that they had a serious suicidal tendency and wanted to conduct self-injury to escape from clinical eucation.[22]

> *"I realized that no matter how hard we worked in our clinical group, that it was the instructor's way or no way. It wasn't our work we were being evaluated on; it was our ability to please her. If we didn't look good, she didn't look good. If we embarrassed her, she would squash us, she would fail us. We felt helpless".*[24]

The consequences of incivility included suffering from physical symptoms. These reactions included sleep disorders, fatigue, sweating, nausea, vomiting, headaches, chest pain, nervousness, palpitations, cardiac and abdominal symptoms, and overeating or appetite loss.[22, 24, 28, 31, 32, 35] In addition, incivility also caused issues with loss of motivation, productivity, and performance.[28, 31, 34, 35] The students' professional engagement was negatively affected by incivility. In nine studies, nursing students expressed incivility as criticism of clinical education and the nursing profession and doubt towards their career choice.[16, 22, 23, 25, 27, 28, 31, 32, 34, 35]

> *"I am making it my duty as a registered nurse to never forget how it felt as a student that was bullied on placement".*[22]
>
> *"Bullying has totally eroded the credibility of the profession in my eyes".*[28]

Synthesized finding 4

Facing faculty incivility in the clinical context, nursing students can develop either negative or positive coping strategies to accept the harsh realities of life or fight incivility.

This synthesized finding originated from 15 findings and was grouped into two categories. Studies noted that nursing students developed different responses to incivility when they perceived uncivil treatment through their education. The categories included negative coping and positive coping. Nine studies described negative coping strategies. Students often felt powerless to deal with incivility, and the most common response was to remove themselves from the situation.[26, 34] Students were reluctant to report the incidences of perceiving incivility and felt that their actions were unlikely to lead to change.[15, 16, 22, 25, 26, 31, 37] They accepted the harsh clinical education as a part of student life.[31] However, some nursing students chose to change their major and left the nursing programme.[24]

> *"'We have to get used to verbal abuse incidents like this. Ultimately, we have to accept the clinical reality. The most important goal is to graduate. My mother is my best counsel'. She keeps saying, 'Be patient! It will come to an end'".*[31]

Eleven studies noted that nursing students confronted incivility by using positive coping strategies. Positive strategies including standing up to report the incivility they perceived to a high level,[16, 22, 24, 30, 31, 35] improving communication with the medical staff,[16, 26, 31, 35, 36] sharing the story with their families and friends,[24, 25, 28, 31, 36] seeking support from other friendly nurse faculty and trusted university staff,[24, 25] sharing the experience in end-of-semester evaluations,[35] trying to understand the staff's viewpoint,[36] developing self-resilience,[22, 26] maintaining self-values and restoring confidence.[23, 36] Many nursing students who had perceived incivility once noted that they would not be disrespectful to students in the future.[22, 26]

> *"Spent the afternoon shadowing a 2nd-year student. She was really helpful and friendly. I found it reassuring that she had experienced the same anxieties and fears".*[36]

> *"I am making it my duty as a registered nurse to never forget how it felt as a student that was bullied on placement... I was shocked that nurses − [supposedly] such a caring profession − could be so ruthless towards students. I think bullying in nursing really needs to stop".*[22]

Synthesized finding 5

Students' individual factors, staff factors, and clinical culture factors place nursing students at risk for incivility. These factors work individually or collectively.

This synthesized finding originated from 15 findings and was grouped into three categories. Although there is absolutely no excuse for medical staff to harass and humiliate nursing students, most incivilities had underlying reasons that led to this behaviour. The possible reasons were categorized into staff-related reasons, student-related reasons, and culture. Staff-related factors were identified as the main trigger for incivility, including conflicts among staff,[29] work overload and workplace stressors,[15, 34-36] personal life stressors,[35] previous encounters with students,[35] limited availability of instructor,[15] limited competency,[15] individuals' characteristics and personalities,[35] misperceptions about university education,[31, 35] and a generation gap.[32, 34]

> *"It is like a lot of the time the nurses are overwhelmed. They have six or seven patients instead of the four that they should have and...they convey their stress on to people. They put it onto others—and it turns into bullying, but it's really you know 'I feel overworked' or 'I'm too told to be in this position' or 'I can't lift like I [used] to".*[34]

According to student-related factors, incivility is a mutual conflict that depends on how well nursing students respect their clinical instructor. Nursing students showing less respect for their instructors was the common trigger for incivility.[21] Notably, two studies noted that students' youth, gender, personalities, and inexperience in the work environment increased their risk of being subjected to incivility.[31, 35] However,

nursing students are a vulnerable population in the clinical environment, which makes them easily targeted and crushed.[22]

Clinical culture is another factor that contributes to incivility towards nursing students. In particular, the included studies showed that bullying was a rite of passage of culture transition from school to the new hierarchical environment.[22, 23, 25, 29, 34] One study showed that a "student not welcome" culture in the clinical setting could also create incivilities.[34]

> *"Some nurses are very nice to students and very helpful and others you get the vibe you know they don't want you there".*[34]

Synthesized finding 6

Both the university and hospital can consistently respond to faculty incivility in clinical education towards nursing students. Building an anti-incivility environment requires that the university and hospital work together.

This synthesized finding originated from eight findings and was grouped into two categories. The last synthesized finding describes suggestions from nursing students for universities and hospitals. The suggestions for universities can be categorized into four sectors:[25, 34] educating and preparing student responses to incivility; having an immediate response person or system; having faculty to follow up and continue monitoring; and having peer support and other opportunities.

> *"The university should have an immediate response person or system to ensure immediate support. We need a phone number or email for help and advice straight away, like you can call and say this has happened".*[25]

Suggestions to hospitals can be categorized into four factors:[23, 31, 34] qualifying preceptors and performing continuous evaluations; having perceived authority as instructors; clarifying the roles of students; and establishing a positive professional role model.

> *"Those nurses are acting as teachers and some people weren't meant to be teachers. They may be good nurses but they're not good teachers, and they need to think about that more in terms of who they're assigning and make the compensation for it so they want to do it, the ones who are good at it want to do it. It should be a regular thing where they're evaluated on it".*[34]

ConQual summary of synthesized findings

The ConQual scores and the summary of the synthesized findings are provided in Table 4. The confidence was low for six synthesized findings, where were downgraded one level due to dependability limitation issues. A mix of unequivocal and credible findings was another reason to downgrade the credibility of all of the included studies

Discussion

Our systematic review and meta-synthesis provided a comprehensive picture of nursing students' experiences with faculty incivility in the available literature. Based on the exhaustive search strategies, eighteen studies were included. Six synthesized findings were identified, covering features of incivility, manifestations of incivility, contributing factors, impacts on students, coping strategies, and suggestions.

The meta-synthesis revealed that in addition to disrespect, feelings of being unwanted and ignored, inequality, and lack of professionalism were identified as important displays of workplace incivility. This finding added to our knowledge that nursing students regarded instructors who acted without professionalism as uncivil, which was different from faculty-to-faculty incivility.[38] In the clinical education setting, nursing students still expect preceptors to be role models and demonstrate positive and constructive manners.[39, 40] Even working with medical teams, most nursing students are subjected to a structured

academic setting during the transition from a student to a nurse.[41, 42] Therefore, nursing student orientation uses the same evaluation standard to measure the behaviours of both clinical preceptors and academic faculty. This result indicates that a qualification assessment and training are essential for clinical nurse preceptors.

Our study also showed that the impact of incivility was very far-reaching. Students who perceived such incivility at work would not only bring home the negative emotions but also would lose motivation in the next few days and doubt their profession choice in the future. Clinical education is the first time that nursing students transit from learning in classrooms to studying in real care environments. Previous studies showed that clinical education was the crucial period when nursing student cultivated professionalism.[10, 11] The experience perceived by the students is highly associated with job satisfaction and turnover intention.[43] Therefore, incivility is a barrier to professional formation and will worsen the shortage of nurses. Incivility in nursing clinical education programmes is particularly crucial during a time of critical nursing shortages worldwide. Universities and hospitals have an ethical mandate to ensure that nursing students and preceptors are practising in areas that do not negatively influence student health and help students form professionalism.[44]

Different from previous discoveries, our study showed that many nursing students adopted positive strategies to cope with incivility. Previous studies noted that students tended to use avoidant strategies when facing uncivil behaviours.[15, 27] The use of negative coping strategies may contribute to increased emotional burdens, being the target of incivility, and holding a grudge against the victimizer.[45] Nevertheless, in recent years, a series of anti-bullying campaigns have popped up everywhere in response to the situation of uncivil behaviours in schools. Ending bullying has become a trend among students.[46] Some studies have argued students should come to a resolution between themselves and the person exhibiting incivility.[47, 48] However, unlike facing a bully, dealing directly with the uncivil person may not be a good option. Incivility manifests as a rude or disrespectful action that is difficult to use to invoke adverse management actions at the organizational level. In our study, seeking help from a trusted person

and organization was the most common strategy used by nursing students. Using indirect confrontation coping strategies can elicit positive results for students, such as accommodating negative emotions, which is beneficial for building good interpersonal work relationships.[24, 25, 49] Additionally, these strategies can protect victims in the hierarchical system.[31, 35] Therefore, hospitals or universities should have an immediate response person or system to help nursing students confronting incivility and to follow up and monitor the development.

We found that work overload and job stress were important factors contributing to incivility. This result is similar to those of previous studies showing that work overload may increase an employee's tendency to display uncivil behaviours and provide them with no time for niceties.[50] A significant relationship exists among workplace incivility, job stress and turnover intention.[51] The consequences of overload and unmanaged stress are incivility. Stress stemming from incivility can also silently kill productivity of staff/students. The vicious cycle of "overload work–work stress- incivility" should be broken. Self-monitoring is an important process during which medical staff should detect, reflect on and assess their own behaviour. In particular, preceptors need to know the emotional triggers and how to curb negative responses. Nurse leaders can provide stress-reducing interventions to lead the organizational cultural to develop a more open communication environment and have less incidences of workplace incivility.

Another issue needs to be considered when interpreting our findings. The levels of confidence across six synthesized findings were downgraded due to dependability issues and a mix of unequivocal and credible findings. Among the 18 included studies, the majority did not report the authors' influences (e.g., roles, beliefs, and value) on the studies, which influenced the dependability of all synthesized findings. We recommend that future studies strengthen the methodological quality of qualitative studies and add credibility to the research findings.

The strength of this study is that we performed a comprehensive search strategy to find all relevant studies in nine academic and four grey literature databases. Both journal articles and theses were included to

provide unbiased results. Another strength is that we used the JBI meta-aggregation method to synthesize qualitative data, which avoided re-interpretation of the original studies. Finally, to the best of our knowledge, no qualitative systematic review has examined this topic.

Limitations

Our study also has limitations. First, similar to all meta-syntheses, the findings are limited by the study quality and the interpretations of the original researchers. Additionally, we only included studies in English. All included studies were conducted in the United States, European countries and Australia. Cultural variation may have resulted in variation in individual responses to incivility. Therefore, the findings can only be generalized to other contexts with a similar culture.

Conclusions

This study synthesized qualitative evidence on the experiences and perceptions of incivility during clinical education of nursing students and evaluated the influence of incivility on student nurses. The findings showed that the experience of incivility in clinical education was common and had negative impacts on nursing students and the nursing profession. We suggest that nursing students should try to cope with incivility positively. Nurse managers and clinical preceptors should be aware of the prevalence and impact of incivility and implement policies and strategies to reduce incivility towards nursing students. Hospitals and universities should have an immediate response person or system to help nursing students confronting incivility and create an open communication environment.

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Author Contributions

Study design: XWJ; Data collection and appraisal: ZZ, XWJ; Data analysis: ZZ, XWJ; Study supervision: HY; Manuscript writing: ZZ, XWJ; Critical revisions for important intellectual content: LL, HY, GMD. All authors revised and accepted the final draft.

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Conflicts of Interests

The authors report no real or perceived interests that relate to this article that can be construed as a conflict of interest.

Data Share Statement

No additional data are available

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Table 1. Results of quality assessment based on JBI critical appraisal checklist for qualitative studies*

	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10
1. Altmiller (2012)[15]	U	U	Y	Y	Y	U	U	U	U	Y
2. Anthony (2011)[16]	U	U	Y	Y	Y	U	U	Y	Y	Y
3. Birks et al. (2017)[22]	U	Y	Y	Y	Y	U	U	Y	Y	Y
4. Cantey (2012)[23]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5. Clark (2008)[24]	U	Y	Y	Y	Y	U	U	Y	Y	Y
6. Courtney-Pratt et al. (2017)[25]	U	Y	Y	Y	Y	U	U	Y	Y	Y
7. Curtis et al. (2007)[26]	U	Y	Y	Y	Y	U	U	Y	Y	Y
8. Del Prato (2013)[27]	U	Y	Y	Y	Y	U	U	Y	Y	Y
9. Hakojarvi et al. (2014)	U	Y	Y	Y	Y	U	U	Y	Y	Y
10. Hoel et al. (2007)[29]	U	U	Y	Y	U	U	U	Y	U	Y
11. Jackson et al. (2011)[30]	U	Y	Y	Y	Y	U	U	Y	Y	Y
12. Lash et al. (2006)[31]	U	Y	Y	Y	Y	U	U	Y	Y	Y
13. Martel (2015)[32]	Y	Y	Y	Y	Y	U	Y	Y	Y	Y
14. Rees et al. (2015)[33]	Y	Y	Y	Y	Y	U	U	Y	Y	Y
15. Smith et al. (2016)[34]	U	Y	Y	Y	Y	U	U	Y	Y	Y
16. Thomas (2015)[35]	Y	Y	Y	Y	Y	U	Y	Y	Y	Y
17. Thomas et al. (2015)[36]	U	Y	Y	Y	Y	U	U	Y	Y	Y
18. Thomas & Burk (2009)[37]	U	U	Y	Y	Y	U	U	Y	Y	Y

*C1= Congruity between the stated philosophical perspective and the research methodology;
C2= Congruity between the research methodology and the research question or objectives
C3= Congruity between the research methodology and the methods used to collect data
C4= Congruity between the research methodology and the representation and analysis of data
C5= There is congruence between the research methodology and the interpretation of results
C6= Locating the researcher culturally or theoretically
C7= Influence of the researcher on the research
C8= Representation of participants and their voices
C9= Ethical approval by an appropriate body
C10= Relationship of conclusions to analysis, or interpretation of the data
Y= Yes; N=No; U=Unclear; NA=Not applicable

664 **Table 2.** Characteristics of the studies

Study (year), Country	Design (data collection method)	Phenomenon of interest	Recruitment and participants	Main findings
Altmiller (2012), US[15]	Phenomenology (focus group interview)	To describe the phenomenon of incivility in undergraduate nursing programmes.	Four universities in the US; Twenty-four undergraduate junior and senior nursing students	Nine themes were identified in this study: 1) unprofessional behaviour; 2) poor communication techniques; 3) power gradient; 4) inequality; 5) loss of control over one's world; 6) stressful clinical environment; 7) authority failure; 8) difficult peer behaviours; and 9) students' views of faculty perceptions
Anthony (2011), US[16]	Descriptive qualitative study (focus group interview)	To describe students' experiences and perceptions of incivility in clinical education.	One nursing school in the US; Twenty-one nursing students	The experience of perceived incivility was categorized into three themes: 1) exclusionary; 2) hostile or rude; and 3) dismissive. Positive experiences were reported when the students were welcomed by the staff.
Birks et al. (2017), Australia[22]	Descriptive qualitative study (open-ended questionnaire)	To describe experiences of bullying and harassment among nursing students during clinical education.	An online platform in Australia; Four hundred and thirty nursing students	Three themes were derived from the analysis: 1) manifestations of bullying and harassment; 2) the perpetrators; and 3) the consequences and impacts.
Cantey (2012), US[23]	Narrative inquiry (semi-structured interview)	To explore the experience of vertical violence among registered nurses during school nurses' clinical education.	One generic class in the US; Four registered nursing students	Three themes were gleaned from the data analysis: 1) rite of passage; 2) professional identity development; and 3) positive professional role model.
Clark (2008), US[24]	Phenomenology (semi-structured interview)	To describe nursing students' experiences of uncivil encounters with nursing faculty.	Four nursing schools in the US; Seven current and former nursing students	Three major themes were identified regarding incivility conducted by faculty: 1) behaving in demeaning and belittling ways; 2) treating students unfairly and subjectively; and 3) pressuring students to conform to unreasonable faculty demands. Three major themes were identified regarding students' emotional responses: 1) feeling traumatized; 2) feeling powerless and helpless; and 3) feeling angry and upset.

Courtney-Pratt et al. (2017), Australia[25]	Mix-methods (semi-structured interviews)	To explore nursing students' experiences with bullying in clinical and academic settings.	One Australian university; Twenty-nine first-, second- and third-year undergraduate nursing students	Four themes were derived from the analysis: 1) manifestations of bullying in clinical and academic settings; 2) impact of experiences on students and the strategies students used to "make sense of" and address bullying; 3) recommendations from students on how to prepare for bullying; and 4) recommendations on how to manage bullying.
Curtis et al. (2007), Australia[26]	Descriptive qualitative study (open-ended questionnaire)	To investigate nursing students' experiences with horizontal violence in the nursing workplace in Australia.	One university in Australia; One hundred and fifty-two second- and third- year nursing students	Five major themes were identified: 1) humiliation and lack of respect; 2) powerlessness and becoming invisible; 3) hierarchical nature of horizontal violence; 4) coping strategies; and 5) future employment choices.
Del Prato (2013), US[27]	Phenomenology (in-depth interviews)	To understand students' experiences with faculty incivility in associate degree nursing education.	One university in the US; Thirteen nursing students from three associate degree nursing education programmes	Faculty incivility was categorized into four themes: 1) demeaning experiences; 2) subjective evaluation; 3) rigid expectations; and 4) targeting and weeding out practices.
Hakojarvi et al. (2014), Finland[28]	Descriptive study (an electronic semi-structured questionnaire)	To describe health care students' (including nursing students) personal experiences with bullying by staff or clinical instructors in clinical settings.	Two universities in Finland; Forty-one health care students	1) Students experienced both verbal and non-verbal bullying during clinical training. 2) Bullying influenced the students' motivation and professional engagement. 3) Some students thought that sharing the experience with their teacher and instructors was useless. However, those students who shared the bullying experience received emotional support and information.
Hoel et al. (2007), UK[29]	Not specified (focus group interview and one-on-one interview)	To explore nursing students' experiences and perceptions of bullying in a clinical setting.	Recruited from universities and an advertisement in the UK; Forty-eight nursing students	1) Students felt exploited, ignored and unwelcome. 2) Bullying experiences had strong effects on the institutionalizing and unwelcoming culture in the clinical setting. 3) Students' coping mechanisms contributed to reproducing

				negative behaviours towards them.
Jackson et al. (2011), Australia[30]	Not specified (open-ended questionnaire)	To explore undergraduate students' experiences of negative behaviours in clinical settings.	An online website in Australia; One hundred and five nursing students from a large Australian university	Three themes were categorized: 1) confronted by contradiction: students as 'other'; 2) organizational aggression as a legitimating device; and 3) resisting 'othering': securing a legitimate identity as a student
Lash et al. (2006), Turkey[31]	Phenomenology (focus group interview)	To describe nursing and midwifery students' experiences with perceived verbal abuse in clinical settings in Turkey.	One university in Turkey; Seventy-three nursing and midwifery students	Four categories were derived from the interviews: 1) experiences of verbal abuse; 2) perceptions of the effects of verbal abuse; 3) methods of coping with verbal abuse; and 4) recommendations to prevent and effectively respond to the verbal abuse
Martel (2015), UK[32]	Phenomenology (semi-structured interviews)	To describe the experiences of nursing students with nursing staff incivility.	One university in the UK; Seven BSN students	Uncivil behaviours were grouped into three themes: 1) lack of receptiveness; 2) belittling; and 3) failing to recognize the assistance of students. Consequences of uncivil behaviours included emotional hurt, loss of confidence, discouragement, fear, demotivation, and unhappiness
Rees et al. (2015), UK[33]	Not specified (individual and group interviews)	To explore dental, nursing, pharmacy and physiotherapy students' experiences with workplace abuse.	Three universities in the UK; Sixty-nine healthcare students (n=13 nursing students)	1) Covert abuse was the most reported type of abuse in the narratives; 2) individual, relational, work and organizational factors contributed to abuse; the perpetrator was the most important factors; 3) most participants acted in the face of their abuse; and d) the perpetrator-recipient relationship was the main contributory factor.
Smith et al. (2016), US[34]	Descriptive qualitative study (focus group interview)	To explore what types of bullying behaviours were encountered by nursing students in the clinical placement and how these encounters impacted them.	Four colleges in the US; Fifty-six undergraduate nursing students	Four categories were identified: 1) bullying behaviours; 2) rationale for bullying; 3) response to bullying; and 4) recommendations to address bullying.
Thomas (2015),	Phenomenology	To understand nursing students' experience with	One university in the US;	Nursing students felt unprepared to effectively respond when

US[35]	(semi-structured interviews)	incivility in a clinical education setting.	Twelve junior and senior nursing students in a baccalaureate nursing programme	encountering incivility and experienced emotional and behavioural harm from the encounters.
Thomas et al. (2015), UK[36]	The classic grounded theory (diary)	To explore the impacts of the first clinical placement on the professional socialization of adult undergraduate student nurses in the UK.	Twenty-six undergraduate adult student nurses in the UK	Incivility is comprised of three stages: 1) stage of dislocation (disillusionment with role, needing benevolence, and being altruistic); 2) stage of status negotiation (significant others, seeking recompense, and brokering for learning); and 3) stage of status relocation (being benevolent, maintaining values, and recanting status).
Thomas & Burk (2009), US[37]	Descriptive study (written stories)	To explore the experiences of injustice perpetrated by staff RNs during nursing students' clinical placement.	One university in the US; Two hundred and twenty-one junior nursing students	Four levels of injustice were described: 1) "We were unwanted and ignored"; 2) "Our assessments were distrusted and disbelieved"; 3) "We were unfairly blamed"; and 4) "I was publicly humiliated"

666 **Table 3**. Synthesized Findings

Findings	Categories	Synthesized Findings
Diverse, overt and covert, verbal and non-verbal (U) Unavoidable, unprepared, pervasive and recurring (U) Ongoing and endless, continued in professional lives (U) Multiple perpetrators, clinical instructors, other nursing staff, Physicians, healthcare assistants, and ward cleaners (U) Difficult to prove (U) Hierarchical (C)	Feature/nature of incivility	1. Different types of incivility can be experienced by nursing students. Some types are noticeable, whereas others can be more subtle and are difficult to prove. Most nursing students are unprepared for incivility from multiple perpetrators.
Failed to provide learning opportunities or guidance (U) Rigid expectations for students' abilities (U) Excessive use of students for legwork or their own gains (U) Arbitrary changes in syllabi, assignments and schedules (U) Being questioned inadequately (C) Constant criticism and negative feedback (U) Not protecting students' safety (U)	Lack of professionalism	2. Faculty incivility in the clinical education context toward nursing students manifests as a lack of professionalism in the workplace, being disrespectful and unfair toward nursing students, and making nursing students feel unwanted and ignored in the workplace. Worse, some manifestations, including physical abuse and sexual harassment, violate the law.
Belittlement (U) Condescending (U) Being intimidated (U) Personality criticism (C) Humiliation in front of staff and patients (U) Talking about students behind their backs (U) Being called derogatory names (U) Being shouted at (U) Hostile body language (eye rolling and avoiding eye contact) (U)	Disrespect	
Feeling like a nuisance (U) Not being involved in nursing activities (U) Refusal to answer, help or support (U) Not being permitted to use staff room (U)	Unwanted and ignored	
Favouritism (U) Being targeted or retaliation (U) Racial/ethnic bias (U) Gender bias (U) Appearance bias (U) Subjective evaluation (U)	Inequality	
Physical abuse (U) Sexual harassment (U)	Other manifestations that violate the law	
Helplessness/hopelessness/powerlessness (U) Loss of self-esteem, worth and confidence (U) Stress, depression, distress, fear, anger, upset, and anxiety (U) Suicidal or self-harm (C)	Psychological symptoms	3. Faculty incivility in the clinical education context not only has a huge physical and emotional impact on nursing students but also influences the professional formation process.

Sleep disorders, fatigue, sweating, tearfulness, nausea, vomiting, headaches, chest pain, palpitations, cardiac and abdominal symptoms, and overeating or appetite loss (U)	Physical symptoms	
Deleterious consequences for patients (C) Doubting profession choice and having the desire to quit nursing (U) Loss of motivation, productivity and performance (U)	Professional formation	
Tolerated and reticent to report (U) Becoming invisible (U) Accept as a part of student life (U) Leave nursing programme (U)	Negative coping	4. Facing faculty incivility in the clinical context, nursing students can develop either negative or positive coping strategies to accept the harsh realities of life or fight incivility.
Standing up to report (U) Improving communication with staff (U) Sharing with families and friends (U) Seeking support from nice nursing faculty (U) Seeking advice from trusted university staff (U) Sharing in end-of-semester evaluations (U) Trying to understand staff's viewpoint (U) Developing self-resilience (C) Maintaining self-values and restoring confidence (U) Being benevolent and not perpetuating incivility (U)	Positive Coping	
Conflicts among staff (U) Workplace stressors and overload (U) Personal life stressor (U) Previous bad encounters with students (U) Limited availability of instructor (U) Limited competency (U) Characteristics and personalities (U) Misperceptions about university education (U) Generation gap (C)	Staff-related factors	5. Students' individual factors, staff factors, and clinical culture factors place nursing students at risk for incivility. These factors work individually or collectively.
Showing less respect (U) Limited power (C) Youth, gender and inexperience (U) Characteristics and personalities (U)	Student-related factors	
Rite of passage/vicious cycle (U) The culture of "students not welcome" (U)	Culture-related factors	
Educate and prepare students' responses to incivility (U) Immediate response person or system (U) Faculty follow up and monitoring (U) Peer support and opportunities (U)	Suggestions to university	6. Both the university and hospital can consistently respond to faculty incivility in clinical education towards nursing students. Building an anti-incivility environment
Qualifications of preceptors and continuous evaluation (U)	Suggestions to hospital	requires that the university and hospital work

Having perceived authority of instructors (C)	together.
Clarifying the role of nursing students (U)	
Positive professional role model (C)	

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669 **Table 4**. ConQual summary of findings

Synthesized Findings	Type of Research	Dependability	Credibility	ConQual Score
1. Different types of incivility can be experienced by nursing students. Some types are noticeable, whereas others can be more subtle and are difficult to prove. Most nursing students are unprepared for incivility from multiple perpetrators.	Qualitative	Downgrade 1 level	Downgrade 1 level	Low
2. Faculty incivility in the clinical education context towards nursing students manifests as a lack of professionalism in the workplace, being disrespectful and unfair towards	Qualitative	Downgrade 1 level	Downgrade 1 level	Low
3. Faculty incivility in the clinical education context not only has a huge physical and emotional impact on nursing students but also influences the professional formation process.	Qualitative	Downgrade 1 level	Downgrade 1 level	Low
4. Facing faculty incivility in the clinical context, nursing students can develop either negative or positive coping strategies to accept the harsh realities of life or fight incivility.	Qualitative	Downgrade 1 level	Downgrade 1 level	Low
5. Students' individual factors, staff factors, and clinical culture factors place nursing students at risk for incivility. These factors work individually or collectively.	Qualitative	Downgrade 1 level	Downgrade 1 level	Low
6. Both the university and hospital can consistently respond to faculty incivility in clinical education towards nursing students. Building an anti-incivility environment requires that the university and hospital work together.	Qualitative	Downgrade 1 level	Downgrade 1 level	Low

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Figure 1 Flow chart of the search strategy and results

Appendix I The ENTREQ statement

Appendix II: Search strategy for PubMed (MEDLINE)

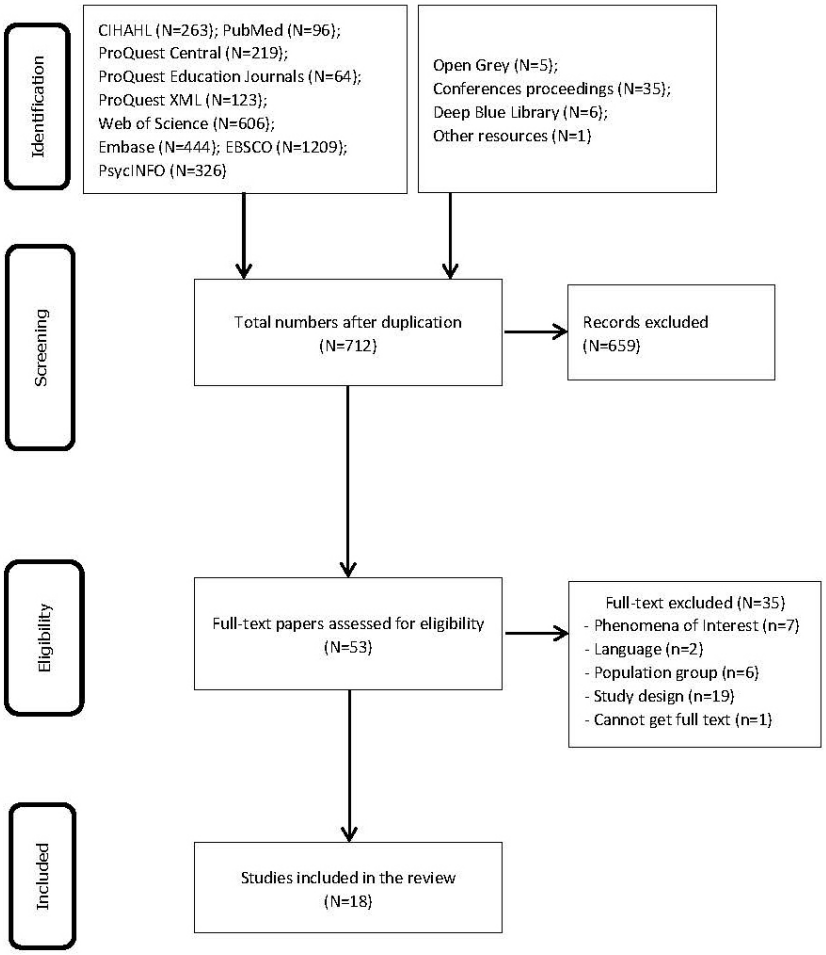

Figure 1 Flow chart of the search strategy and results

90x90mm (300 x 300 DPI)

Appendix I the ENTREQ statement

Section/topic	#	Checklist item	Reported on Page #
Aim	1	State the research question the synthesis addresses.	P5
Synthesis methodology	2	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	P5
Approach to searching	3	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved).	P6
Inclusion criteria	4	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).	P5
Data sources	5	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organizational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources.	P6
Electronic Search strategy	6	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits).	P6 & Appendix II.
Study screening methods	7	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies).	P6
Study characteristics	8	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	Table 2
Study selection results	9	Identify the number of studies screened and provide reasons for study exclusion (e,g, for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).	Fig. 1

Rationale for appraisal	10	Rationale for appraisal	P6
Appraisal items	11	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	Table 1
Appraisal process	12	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	P6
Appraisal results	13	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	Table 1
Data extraction	14	Indicate which sections of the primary studies were analyzed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software).	P6
Software	15	State the computer software used, if any.	P6-7
Number of reviewers	16	Identify who was involved in coding and analysis.	P7
Coding	17	Describe the process for coding of data (e.g. line by line coding to search for concepts).	P7
Study comparison	18	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	P7
Derivation of themes	19	Explain whether the process of deriving the themes or constructs was inductive or deductive.	P7
Quotations	20	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation.	P10-P17
Synthesis output	21	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	P10-P17

Appendix II: Search strategy for PubMed (MEDLINE)

Date: 2018.01.06

Database: PubMed (MEDLINE)

Set #		Results
1	incivility [MeSH] OR bullying[MeSH] OR "workplace violence" [MeSH] OR incivilit*[tiab] OR bully[tiab] OR uncivil[tiab] or aggression*[tiab] or harass* [tiab] OR mob [tiab] mobs [tiab] OR mobbing [tiab] OR victimiz* [tiab] OR ill-treat*[tiab] or abuse*[tiab] OR [tiab] OR oppress*[tiab] OR " horizontal violence"[tiab] OR "lateral violence" [tiab] OR disruptive[tiab] OR mistreat*[tiab] OR dilemma*[tiab] OR distress*[tiab] OR violen*[tiab] OR "nurses eat their young"[tiab]	12207
2	nurse [MeSH] OR nurs*[tiab] OR health[tiab]	442373
3	student[MeSH] OR student*[tiab] OR undergraduate* [tiab] OR graduate* [tiab]	298999
4	Hospitals[MeSH] OR workplace[MeSH] OR Hospital*[tiab] OR clinic [tiab] clinical [tiab] OR workplace*[tiab] OR work[tiab] OR "job site*" [tiab]	1144910
5	#1 AND #2 AND #3 AND #4	96